

Bill No. SB 404

Barcode 100596

Proposed Committee Substitute by the Committee on Health and
Human Services Appropriations

1 A bill to be entitled

2 An act relating to health care; amending s.

3 400.23, F.S.; delaying provisions requiring a

4 nursing home staffing increase; amending ss.

5 409.903, 409.904, F.S.; deleting certain

6 limitations on services to the medically needy;

7 amending s. 409.906, F.S., relating to optional

8 Medicaid services; providing for adult denture

9 services; repealing s. 409.9065, F.S., relating

10 to pharmaceutical expense assistance; amending

11 s. 409.908, F.S.; revising guidelines relating

12 to reimbursement of Medicaid providers;

13 amending ss. 409.9112, 409.9113, 409.9117,

14 F.S., relating to the hospital disproportionate

15 share program; deleting obsolete provisions;

16 amending s. 409.91195, F.S.; revising

17 provisions relating to the Medicaid

18 Pharmaceutical and Therapeutics Committee and

19 its duties with respect to developing a

20 preferred drug list; amending s. 409.912, F.S.;

21 revising the Medicaid prescribed drug spending

22 control program; eliminating case management

23 fees; directing the Agency for Health Care

24 Administration to implement, and authorizing it

25 to seek federal waivers for, the program of

26 all-inclusive care for children; amending s.

27 409.9124, F.S.; requiring the Agency for Health

28 Care Administration to publish managed care

29 reimbursement rates annually; providing

30 effective dates.

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1 Be It Enacted by the Legislature of the State of Florida:

2

3 Section 1. Paragraph (a) of subsection (3) of section
4 400.23, Florida Statutes, is amended to read:

5 400.23 Rules; evaluation and deficiencies; licensure
6 status.--

7 (3)(a) The agency shall adopt rules providing ~~for the~~
8 minimum staffing requirements for nursing homes. These
9 requirements shall include, for each nursing home facility, a
10 minimum certified nursing assistant staffing of 2.3 hours of
11 direct care per resident per day beginning January 1, 2002,
12 increasing to 2.6 hours of direct care per resident per day
13 beginning January 1, 2003, and increasing to 2.9 hours of
14 direct care per resident per day beginning July 1, 2006 ~~2005~~.
15 Beginning January 1, 2002, no facility shall staff below one
16 certified nursing assistant per 20 residents, and a minimum
17 licensed nursing staffing of 1.0 hour of direct resident care
18 per resident per day but never below one licensed nurse per 40
19 residents. Nursing assistants employed under s. 400.211(2) may
20 be included in computing the staffing ratio for certified
21 nursing assistants only if they provide nursing assistance
22 services to residents on a full-time basis. Each nursing home
23 must document compliance with staffing standards as required
24 under this paragraph and post daily the names of staff on duty
25 for the benefit of facility residents and the public. The
26 agency shall recognize the use of licensed nurses for
27 compliance with minimum staffing requirements for certified
28 nursing assistants, provided that the facility otherwise meets
29 the minimum staffing requirements for licensed nurses and that
30 the licensed nurses ~~so recognized~~ are performing the duties of
31 a certified nursing assistant. Unless otherwise approved by

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1 the agency, licensed nurses counted toward the minimum
2 staffing requirements for certified nursing assistants must
3 exclusively perform the duties of a certified nursing
4 assistant for the entire shift and ~~shall~~ not also be counted
5 toward the minimum staffing requirements for licensed nurses.
6 If the agency approved a facility's request to use a licensed
7 nurse to perform both licensed nursing and certified nursing
8 assistant duties, the facility must allocate the amount of
9 staff time specifically spent on certified nursing assistant
10 duties for the purpose of documenting compliance with minimum
11 staffing requirements for certified and licensed nursing
12 staff. In no event may the hours of a licensed nurse with dual
13 job responsibilities be counted twice.

14 Section 2. Subsection (5) of section 409.903, Florida
15 Statutes, is amended to read:

16 409.903 Mandatory payments for eligible persons.--The
17 agency shall make payments for medical assistance and related
18 services on behalf of the following persons who the
19 department, or the Social Security Administration by contract
20 with the Department of Children and Family Services,
21 determines to be eligible, subject to the income, assets, and
22 categorical eligibility tests set forth in federal and state
23 law. Payment on behalf of these Medicaid eligible persons is
24 subject to the availability of moneys and any limitations
25 established by the General Appropriations Act or chapter 216.

26 (5) A pregnant woman for the duration of her pregnancy
27 and for the postpartum period as defined in federal law and
28 rule, or a child under age 1, if either is living in a family
29 that has an income which is at or below 150 percent of the
30 most current federal poverty level, or, effective January 1,
31 1992, that has an income which is at or below 185 percent of

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1 the most current federal poverty level. Such a person is not
2 subject to an assets test. Further, a pregnant woman who
3 applies for eligibility for the Medicaid program through a
4 qualified Medicaid provider must be offered the opportunity,
5 subject to federal rules, to be made presumptively eligible
6 for the Medicaid program. ~~Effective July 1, 2005, eligibility~~
7 ~~for Medicaid services is eliminated for women who have incomes~~
8 ~~above 150 percent of the most current federal poverty level.~~

9 Section 3. Subsections (1) and (2) of section 409.904,
10 Florida Statutes, are amended to read:

11 409.904 Optional payments for eligible persons.--The
12 agency may make payments for medical assistance and related
13 services on behalf of the following persons who are determined
14 to be eligible subject to the income, assets, and categorical
15 eligibility tests set forth in federal and state law. Payment
16 on behalf of these Medicaid eligible persons is subject to the
17 availability of moneys and any limitations established by the
18 General Appropriations Act or chapter 216.

19 (1) (a) From July 1, 2005, through December 31, 2005, a
20 person who is age 65 or older or is determined to be disabled,
21 whose income is at or below 88 percent of federal poverty
22 level, and whose assets do not exceed established limitations.

23 (b) Effective January 1, 2006, and subject to federal
24 waiver approval, a person who is age 65 or older or is
25 determined to be disabled, whose income is at or below 88
26 percent of the federal poverty level, whose assets do not
27 exceed established limitations, and who is not eligible for
28 Medicare or, if eligible for Medicare, is also eligible for
29 and receiving Medicaid-covered institutional care services,
30 hospice services, or home and community-based services. The
31 agency shall seek federal authorization through a waiver to

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1 provide this coverage.

2 (2) A family, a pregnant woman, a child under age 21,
3 a person age 65 or over, or a blind or disabled person, who
4 would be eligible under any group listed in s. 409.903(1),
5 (2), or (3), except that the income or assets of such family
6 or person exceed established limitations. For a family or
7 person in one of these coverage groups, medical expenses are
8 deductible from income in accordance with federal requirements
9 in order to make a determination of eligibility. A family or
10 person eligible under the coverage known as the "medically
11 needy," is eligible to receive the same services as other
12 Medicaid recipients, with the exception of services in skilled
13 nursing facilities and intermediate care facilities for the
14 developmentally disabled. ~~Effective July 1, 2005, the~~
15 ~~medically needy are eligible for prescribed drug services~~
16 ~~only.~~

17 Section 4. Paragraph (b) of subsection (1) of section
18 409.906, Florida Statutes, is amended to read:

19 409.906 Optional Medicaid services.--Subject to
20 specific appropriations, the agency may make payments for
21 services which are optional to the state under Title XIX of
22 the Social Security Act and are furnished by Medicaid
23 providers to recipients who are determined to be eligible on
24 the dates on which the services were provided. Any optional
25 service that is provided shall be provided only when medically
26 necessary and in accordance with state and federal law.
27 Optional services rendered by providers in mobile units to
28 Medicaid recipients may be restricted or prohibited by the
29 agency. Nothing in this section shall be construed to prevent
30 or limit the agency from adjusting fees, reimbursement rates,
31 lengths of stay, number of visits, or number of services, or

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1 making any other adjustments necessary to comply with the
2 availability of moneys and any limitations or directions
3 provided for in the General Appropriations Act or chapter 216.
4 If necessary to safeguard the state's systems of providing
5 services to elderly and disabled persons and subject to the
6 notice and review provisions of s. 216.177, the Governor may
7 direct the Agency for Health Care Administration to amend the
8 Medicaid state plan to delete the optional Medicaid service
9 known as "Intermediate Care Facilities for the Developmentally
10 Disabled." Optional services may include:

11 (1) ADULT DENTAL SERVICES.--

12 (b) Beginning January 1, 2005, the agency may pay for
13 dentures, the procedures required to seat dentures, and the
14 repair and relining of dentures, provided by or under the
15 direction of a licensed dentist, for a recipient who is 21
16 years of age or older. ~~This paragraph is repealed effective~~
17 ~~July 1, 2005.~~

18 Section 5. Effective January 1, 2006, section
19 409.9065, Florida Statutes, is repealed.

20 Section 6. Paragraph (a) of subsection (1) and
21 paragraph (b) of subsection (2) of section 409.908, Florida
22 Statutes, are amended to read:

23 409.908 Reimbursement of Medicaid providers.--Subject
24 to specific appropriations, the agency shall reimburse
25 Medicaid providers, in accordance with state and federal law,
26 according to methodologies set forth in the rules of the
27 agency and in policy manuals and handbooks incorporated by
28 reference therein. These methodologies may include fee
29 schedules, reimbursement methods based on cost reporting,
30 negotiated fees, competitive bidding pursuant to s. 287.057,
31 and other mechanisms the agency considers efficient and

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1 effective for purchasing services or goods on behalf of
2 recipients. If a provider is reimbursed based on cost
3 reporting and submits a cost report late and that cost report
4 would have been used to set a lower reimbursement rate for a
5 rate semester, then the provider's rate for that semester
6 shall be retroactively calculated using the new cost report,
7 and full payment at the recalculated rate shall be effected
8 retroactively. Medicare-granted extensions for filing cost
9 reports, if applicable, shall also apply to Medicaid cost
10 reports. Payment for Medicaid compensable services made on
11 behalf of Medicaid eligible persons is subject to the
12 availability of moneys and any limitations or directions
13 provided for in the General Appropriations Act or chapter 216.
14 Further, nothing in this section shall be construed to prevent
15 or limit the agency from adjusting fees, reimbursement rates,
16 lengths of stay, number of visits, or number of services, or
17 making any other adjustments necessary to comply with the
18 availability of moneys and any limitations or directions
19 provided for in the General Appropriations Act, provided the
20 adjustment is consistent with legislative intent.

21 (1) Reimbursement to hospitals licensed under part I
22 of chapter 395 must be made prospectively or on the basis of
23 negotiation.

24 (a) Reimbursement for inpatient care is limited as
25 provided for in s. 409.905(5), except for:

26 1. The raising of rate reimbursement caps, excluding
27 rural hospitals.

28 2. Recognition of the costs of graduate medical
29 education.

30 3. Other methodologies recognized in the General
31 Appropriations Act.

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1 ~~4. Hospital inpatient rates shall be reduced by 6~~
2 ~~percent effective July 1, 2001, and restored effective April~~
3 ~~1, 2002.~~

4
5 During the years funds are transferred from the Department of
6 Health, any reimbursement supported by such funds shall be
7 subject to certification by the Department of Health that the
8 hospital has complied with s. 381.0403. The agency is
9 authorized to receive funds from state entities, including,
10 but not limited to, the Department of Health, local
11 governments, and other local political subdivisions, for the
12 purpose of making special exception payments, including
13 federal matching funds, through the Medicaid inpatient
14 reimbursement methodologies. Funds received from state
15 entities or local governments for this purpose shall be
16 separately accounted for and shall not be commingled with
17 other state or local funds in any manner. The agency may
18 certify all local governmental funds used as state match under
19 Title XIX of the Social Security Act, to the extent that the
20 identified local health care provider that is otherwise
21 entitled to and is contracted to receive such local funds is
22 the benefactor under the state's Medicaid program as
23 determined under the General Appropriations Act and pursuant
24 to an agreement between the Agency for Health Care
25 Administration and the local governmental entity. The local
26 governmental entity shall use a certification form prescribed
27 by the agency. At a minimum, the certification form shall
28 identify the amount being certified and describe the
29 relationship between the certifying local governmental entity
30 and the local health care provider. The agency shall prepare
31 an annual statement of impact which documents the specific

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1 activities undertaken during the previous fiscal year pursuant
2 to this paragraph, to be submitted to the Legislature no later
3 than January 1, annually.

4 (2)

5 (b) Subject to any limitations or directions provided
6 for in the General Appropriations Act, the agency shall
7 establish and implement a Florida Title XIX Long-Term Care
8 Reimbursement Plan (Medicaid) for nursing home care in order
9 to provide care and services in conformance with the
10 applicable state and federal laws, rules, regulations, and
11 quality and safety standards and to ensure that individuals
12 eligible for medical assistance have reasonable geographic
13 access to such care.

14 1. Changes of ownership or of licensed operator do not
15 qualify for increases in reimbursement rates associated with
16 the change of ownership or of licensed operator. The agency
17 shall amend the Title XIX Long Term Care Reimbursement Plan to
18 provide that the initial nursing home reimbursement rates, for
19 the operating, patient care, and MAR components, associated
20 with related and unrelated party changes of ownership or
21 licensed operator filed on or after September 1, 2001, are
22 equivalent to the previous owner's reimbursement rate.

23 2. The agency shall amend the long-term care
24 reimbursement plan and cost reporting system to create direct
25 care and indirect care subcomponents of the patient care
26 component of the per diem rate. These two subcomponents
27 together shall equal the patient care component of the per
28 diem rate. Separate cost-based ceilings shall be calculated
29 for each patient care subcomponent. The direct care and
30 indirect care subcomponents ~~subcomponent~~ of the per diem rate
31 ~~shall be limited by the cost-based class ceiling, and the~~

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1 ~~indirect care subcomponent~~ shall be limited by the lower of a
2 ~~the~~ cost-based class ceiling, ~~a by the~~ target rate class
3 ceiling, or ~~an by the~~ individual provider target for each
4 subcomponent. ~~The agency shall adjust the patient care~~
5 ~~component effective January 1, 2002.~~ The cost to adjust the
6 direct care subcomponent shall be net of the total funds
7 previously allocated for the case mix add-on. ~~The agency shall~~
8 ~~make the required changes to the nursing home cost reporting~~
9 ~~forms to implement this requirement effective January 1, 2002.~~

10 3. The direct care subcomponent shall include salaries
11 and benefits of direct care staff providing nursing services
12 including registered nurses, licensed practical nurses, and
13 certified nursing assistants who deliver care directly to
14 residents in the nursing home facility. This excludes nursing
15 administration, minimum data set MDS, and care plan
16 coordinators, staff development, and staffing coordinator.

17 4. All other patient care costs shall be included in
18 the indirect care cost subcomponent of the patient care per
19 diem rate. There shall be no costs directly or indirectly
20 allocated to the direct care subcomponent from a home office
21 or management company.

22 5. On July 1 of each year, the agency shall report to
23 the Legislature direct and indirect care costs, including
24 average direct and indirect care costs per resident per
25 facility and direct care and indirect care salaries and
26 benefits per category of staff member per facility.

27 6. In order to offset the cost of general and
28 professional liability insurance, the agency shall amend the
29 plan to allow for interim rate adjustments to reflect
30 increases in the cost of general or professional liability
31 insurance for nursing homes. This provision shall be

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1 implemented to the extent existing appropriations are
2 available.

3
4 It is the intent of the Legislature that the reimbursement
5 plan achieve the goal of providing access to health care for
6 nursing home residents who require large amounts of care while
7 encouraging diversion services as an alternative to nursing
8 home care for residents who can be served within the
9 community. The agency shall base the establishment of any
10 maximum rate of payment, whether overall or component, on the
11 available moneys as provided for in the General Appropriations
12 Act. The agency may base the maximum rate of payment on the
13 results of scientifically valid analysis and conclusions
14 derived from objective statistical data pertinent to the
15 particular maximum rate of payment.

16 Section 7. Section 409.9112, Florida Statutes, is
17 amended to read:

18 409.9112 Disproportionate share program for regional
19 perinatal intensive care centers.--In addition to the payments
20 made under s. 409.911, the Agency for Health Care
21 Administration shall design and implement a system of making
22 disproportionate share payments to those hospitals that
23 participate in the regional perinatal intensive care center
24 program established pursuant to chapter 383. This system of
25 payments shall conform with federal requirements and shall
26 distribute funds in each fiscal year for which an
27 appropriation is made by making quarterly Medicaid payments.
28 Notwithstanding the provisions of s. 409.915, counties are
29 exempt from contributing toward the cost of this special
30 reimbursement for hospitals serving a disproportionate share
31 of low-income patients. For the state fiscal year 2005-2006

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1 ~~2004-2005, the agency shall not distribute moneys under the~~
2 ~~regional perinatal intensive care centers disproportionate~~
3 ~~share program, except as noted in subsection (2). In the event~~
4 ~~the Centers for Medicare and Medicaid Services do not approve~~
5 ~~Florida's inpatient hospital state plan amendment for the~~
6 ~~public disproportionate share program by January 1, 2005, the~~
7 ~~agency may make payments to hospitals under the regional~~
8 ~~perinatal intensive care centers disproportionate share~~
9 ~~program.~~

10 (1) The following formula shall be used by the agency
11 to calculate the total amount earned for hospitals that
12 participate in the regional perinatal intensive care center
13 program:

$$TAE = HDSP/THDSP$$

17 Where:

18 TAE = total amount earned by a regional perinatal
19 intensive care center.

20 HDSP = the prior state fiscal year regional perinatal
21 intensive care center disproportionate share payment to the
22 individual hospital.

23 THDSP = the prior state fiscal year total regional
24 perinatal intensive care center disproportionate share
25 payments to all hospitals.

27 (2) The total additional payment for hospitals that
28 participate in the regional perinatal intensive care center
29 program shall be calculated by the agency as follows:

$$TAP = TAE \times TA$$

1

2 Where:

3 TAP = total additional payment for a regional perinatal
4 intensive care center.

5 TAE = total amount earned by a regional perinatal
6 intensive care center.

7 TA = total appropriation for the regional perinatal
8 intensive care center disproportionate share program.

9

10 (3) In order to receive payments under this section, a
11 hospital must be participating in the regional perinatal
12 intensive care center program pursuant to chapter 383 and must
13 meet the following additional requirements:

14 (a) Agree to conform to all departmental and agency
15 requirements to ensure high quality in the provision of
16 services, including criteria adopted by departmental and
17 agency rule concerning staffing ratios, medical records,
18 standards of care, equipment, space, and such other standards
19 and criteria as the department and agency deem appropriate as
20 specified by rule.

21 (b) Agree to provide information to the department and
22 agency, in a form and manner to be prescribed by rule of the
23 department and agency, concerning the care provided to all
24 patients in neonatal intensive care centers and high-risk
25 maternity care.

26 (c) Agree to accept all patients for neonatal
27 intensive care and high-risk maternity care, regardless of
28 ability to pay, on a functional space-available basis.

29 (d) Agree to develop arrangements with other maternity
30 and neonatal care providers in the hospital's region for the
31 appropriate receipt and transfer of patients in need of

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1 specialized maternity and neonatal intensive care services.

2 (e) Agree to establish and provide a developmental
3 evaluation and services program for certain high-risk
4 neonates, as prescribed and defined by rule of the department.

5 (f) Agree to sponsor a program of continuing education
6 in perinatal care for health care professionals within the
7 region of the hospital, as specified by rule.

8 (g) Agree to provide backup and referral services to
9 the department's county health departments and other
10 low-income perinatal providers within the hospital's region,
11 including the development of written agreements between these
12 organizations and the hospital.

13 (h) Agree to arrange for transportation for high-risk
14 obstetrical patients and neonates in need of transfer from the
15 community to the hospital or from the hospital to another more
16 appropriate facility.

17 (4) Hospitals which fail to comply with any of the
18 conditions in subsection (3) or the applicable rules of the
19 department and agency shall not receive any payments under
20 this section until full compliance is achieved. A hospital
21 which is not in compliance in two or more consecutive quarters
22 shall not receive its share of the funds. Any forfeited funds
23 shall be distributed by the remaining participating regional
24 perinatal intensive care center program hospitals.

25 Section 8. Section 409.9113, Florida Statutes, is
26 amended to read:

27 409.9113 Disproportionate share program for teaching
28 hospitals.--In addition to the payments made under ss. 409.911
29 and 409.9112, the Agency for Health Care Administration shall
30 make disproportionate share payments to statutorily defined
31 teaching hospitals for their increased costs associated with

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1 medical education programs and for tertiary health care
2 services provided to the indigent. This system of payments
3 shall conform with federal requirements and shall distribute
4 funds in each fiscal year for which an appropriation is made
5 by making quarterly Medicaid payments. Notwithstanding s.
6 409.915, counties are exempt from contributing toward the cost
7 of this special reimbursement for hospitals serving a
8 disproportionate share of low-income patients. For the state
9 fiscal year 2005-2006 ~~2004-2005~~, the agency shall not
10 distribute moneys under the teaching hospital disproportionate
11 share program, ~~except as noted in subsection (2). In the event~~
12 ~~the Centers for Medicare and Medicaid Services do not approve~~
13 ~~Florida's inpatient hospital state plan amendment for the~~
14 ~~public disproportionate share program by January 1, 2005, the~~
15 ~~agency may make payments to hospitals under the teaching~~
16 ~~hospital disproportionate share program.~~

17 (1) On or before September 15 of each year, the Agency
18 for Health Care Administration shall calculate an allocation
19 fraction to be used for distributing funds to state statutory
20 teaching hospitals. Subsequent to the end of each quarter of
21 the state fiscal year, the agency shall distribute to each
22 statutory teaching hospital, as defined in s. 408.07, an
23 amount determined by multiplying one-fourth of the funds
24 appropriated for this purpose by the Legislature times such
25 hospital's allocation fraction. The allocation fraction for
26 each such hospital shall be determined by the sum of three
27 primary factors, divided by three. The primary factors are:

28 (a) The number of nationally accredited graduate
29 medical education programs offered by the hospital, including
30 programs accredited by the Accreditation Council for Graduate
31 Medical Education and the combined Internal Medicine and

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1 Pediatrics programs acceptable to both the American Board of
2 Internal Medicine and the American Board of Pediatrics at the
3 beginning of the state fiscal year preceding the date on which
4 the allocation fraction is calculated. The numerical value of
5 this factor is the fraction that the hospital represents of
6 the total number of programs, where the total is computed for
7 all state statutory teaching hospitals.

8 (b) The number of full-time equivalent trainees in the
9 hospital, which comprises two components:

10 1. The number of trainees enrolled in nationally
11 accredited graduate medical education programs, as defined in
12 paragraph (a). Full-time equivalents are computed using the
13 fraction of the year during which each trainee is primarily
14 assigned to the given institution, over the state fiscal year
15 preceding the date on which the allocation fraction is
16 calculated. The numerical value of this factor is the fraction
17 that the hospital represents of the total number of full-time
18 equivalent trainees enrolled in accredited graduate programs,
19 where the total is computed for all state statutory teaching
20 hospitals.

21 2. The number of medical students enrolled in
22 accredited colleges of medicine and engaged in clinical
23 activities, including required clinical clerkships and
24 clinical electives. Full-time equivalents are computed using
25 the fraction of the year during which each trainee is
26 primarily assigned to the given institution, over the course
27 of the state fiscal year preceding the date on which the
28 allocation fraction is calculated. The numerical value of this
29 factor is the fraction that the given hospital represents of
30 the total number of full-time equivalent students enrolled in
31 accredited colleges of medicine, where the total is computed

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1 for all state statutory teaching hospitals.

2

3 The primary factor for full-time equivalent trainees is
4 computed as the sum of these two components, divided by two.

5 (c) A service index that comprises three components:

6 1. The Agency for Health Care Administration Service
7 Index, computed by applying the standard Service Inventory
8 Scores established by the Agency for Health Care
9 Administration to services offered by the given hospital, as
10 reported on Worksheet A-2 for the last fiscal year reported to
11 the agency before the date on which the allocation fraction is
12 calculated. The numerical value of this factor is the
13 fraction that the given hospital represents of the total
14 Agency for Health Care Administration Service Index values,
15 where the total is computed for all state statutory teaching
16 hospitals.

17 2. A volume-weighted service index, computed by
18 applying the standard Service Inventory Scores established by
19 the Agency for Health Care Administration to the volume of
20 each service, expressed in terms of the standard units of
21 measure reported on Worksheet A-2 for the last fiscal year
22 reported to the agency before the date on which the allocation
23 factor is calculated. The numerical value of this factor is
24 the fraction that the given hospital represents of the total
25 volume-weighted service index values, where the total is
26 computed for all state statutory teaching hospitals.

27 3. Total Medicaid payments to each hospital for direct
28 inpatient and outpatient services during the fiscal year
29 preceding the date on which the allocation factor is
30 calculated. This includes payments made to each hospital for
31 such services by Medicaid prepaid health plans, whether the

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1 plan was administered by the hospital or not. The numerical
2 value of this factor is the fraction that each hospital
3 represents of the total of such Medicaid payments, where the
4 total is computed for all state statutory teaching hospitals.

5
6 The primary factor for the service index is computed as the
7 sum of these three components, divided by three.

8 (2) By October 1 of each year, the agency shall use
9 the following formula to calculate the maximum additional
10 disproportionate share payment for statutorily defined
11 teaching hospitals:

$$\text{TAP} = \text{THAF} \times \text{A}$$

12
13
14
15 Where:

16 TAP = total additional payment.

17 THAF = teaching hospital allocation factor.

18 A = amount appropriated for a teaching hospital
19 disproportionate share program.

20 Section 9. Section 409.9117, Florida Statutes, is
21 amended to read:

22 409.9117 Primary care disproportionate share
23 program.--For the state fiscal year 2005-2006 ~~2004-2005~~, the
24 agency shall not distribute moneys under the primary care
25 disproportionate share program, ~~except as noted in subsection~~
26 ~~(2). In the event the Centers for Medicare and Medicaid~~
27 ~~Services do not approve Florida's inpatient hospital state~~
28 ~~plan amendment for the public disproportionate share program~~
29 ~~by January 1, 2005, the agency may make payments to hospitals~~
30 ~~under the primary care disproportionate share program.~~

31 (1) If federal funds are available for

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1 disproportionate share programs in addition to those otherwise
2 provided by law, there shall be created a primary care
3 disproportionate share program.

4 (2) The following formula shall be used by the agency
5 to calculate the total amount earned for hospitals that
6 participate in the primary care disproportionate share
7 program:

$$8 \qquad \qquad \qquad 9 \qquad \qquad \qquad TAE = HDSP/THDSP$$

10

11 Where:

12 TAE = total amount earned by a hospital participating
13 in the primary care disproportionate share program.

14 HDSP = the prior state fiscal year primary care
15 disproportionate share payment to the individual hospital.

16 THDSP = the prior state fiscal year total primary care
17 disproportionate share payments to all hospitals.

18

19 (3) The total additional payment for hospitals that
20 participate in the primary care disproportionate share program
21 shall be calculated by the agency as follows:

22

$$23 \qquad \qquad \qquad TAP = TAE \times TA$$

24

25 Where:

26 TAP = total additional payment for a primary care
27 hospital.

28 TAE = total amount earned by a primary care hospital.

29 TA = total appropriation for the primary care
30 disproportionate share program.

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1 (4) In the establishment and funding of this program,
2 the agency shall use the following criteria in addition to
3 those specified in s. 409.911, payments may not be made to a
4 hospital unless the hospital agrees to:

5 (a) Cooperate with a Medicaid prepaid health plan, if
6 one exists in the community.

7 (b) Ensure the availability of primary and specialty
8 care physicians to Medicaid recipients who are not enrolled in
9 a prepaid capitated arrangement and who are in need of access
10 to such physicians.

11 (c) Coordinate and provide primary care services free
12 of charge, except copayments, to all persons with incomes up
13 to 100 percent of the federal poverty level who are not
14 otherwise covered by Medicaid or another program administered
15 by a governmental entity, and to provide such services based
16 on a sliding fee scale to all persons with incomes up to 200
17 percent of the federal poverty level who are not otherwise
18 covered by Medicaid or another program administered by a
19 governmental entity, except that eligibility may be limited to
20 persons who reside within a more limited area, as agreed to by
21 the agency and the hospital.

22 (d) Contract with any federally qualified health
23 center, if one exists within the agreed geopolitical
24 boundaries, concerning the provision of primary care services,
25 in order to guarantee delivery of services in a nonduplicative
26 fashion, and to provide for referral arrangements, privileges,
27 and admissions, as appropriate. The hospital shall agree to
28 provide at an onsite or offsite facility primary care services
29 within 24 hours to which all Medicaid recipients and persons
30 eligible under this paragraph who do not require emergency
31 room services are referred during normal daylight hours.

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1 (e) Cooperate with the agency, the county, and other
2 entities to ensure the provision of certain public health
3 services, case management, referral and acceptance of
4 patients, and sharing of epidemiological data, as the agency
5 and the hospital find mutually necessary and desirable to
6 promote and protect the public health within the agreed
7 geopolitical boundaries.

8 (f) In cooperation with the county in which the
9 hospital resides, develop a low-cost, outpatient, prepaid
10 health care program to persons who are not eligible for the
11 Medicaid program, and who reside within the area.

12 (g) Provide inpatient services to residents within the
13 area who are not eligible for Medicaid or Medicare, and who do
14 not have private health insurance, regardless of ability to
15 pay, on the basis of available space, except that nothing
16 shall prevent the hospital from establishing bill collection
17 programs based on ability to pay.

18 (h) Work with the Florida Healthy Kids Corporation,
19 the Florida Health Care Purchasing Cooperative, and business
20 health coalitions, as appropriate, to develop a feasibility
21 study and plan to provide a low-cost comprehensive health
22 insurance plan to persons who reside within the area and who
23 do not have access to such a plan.

24 (i) Work with public health officials and other
25 experts to provide community health education and prevention
26 activities designed to promote healthy lifestyles and
27 appropriate use of health services.

28 (j) Work with the local health council to develop a
29 plan for promoting access to affordable health care services
30 for all persons who reside within the area, including, but not
31 limited to, public health services, primary care services,

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1 inpatient services, and affordable health insurance generally.

2

3 Any hospital that fails to comply with any of the provisions
4 of this subsection, or any other contractual condition, may
5 not receive payments under this section until full compliance
6 is achieved.

7 Section 10. Section 409.91195, Florida Statutes, is
8 amended to read:

9 409.91195 Medicaid Pharmaceutical and Therapeutics
10 Committee.--There is created a Medicaid Pharmaceutical and
11 Therapeutics Committee within the agency ~~for Health Care~~
12 ~~Administration~~ for the purpose of developing a Medicaid
13 preferred drug list ~~formulary pursuant to 42 U.S.C. s.~~
14 ~~1396r-8.~~

15 (1) The ~~Medicaid Pharmaceutical and Therapeutics~~
16 committee shall be comprised ~~as specified in 42 U.S.C. s.~~
17 ~~1396r-8 and consist~~ of 11 members appointed by the Governor.
18 Four members shall be physicians, licensed under chapter 458;
19 one member licensed under chapter 459; five members shall be
20 pharmacists licensed under chapter 465; and one member shall
21 be a consumer representative. The members shall be appointed
22 to serve for terms of 2 years from the date of their
23 appointment. Members may be appointed to more than one term.
24 The agency ~~for Health Care Administration~~ shall serve as staff
25 for the committee and assist them with all ministerial duties.
26 The Governor shall ensure that at least some of the members of
27 the ~~Medicaid Pharmaceutical and Therapeutics~~ committee
28 represent Medicaid participating physicians and pharmacies
29 serving all segments and diversity of the Medicaid population,
30 and have experience in either developing or practicing under a
31 preferred drug list ~~formulary~~. At least one of the members

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1 shall represent the interests of pharmaceutical manufacturers.

2 (2) Committee members shall select a chairperson and a
3 vice chairperson each year from the committee membership.

4 (3) The committee shall meet at least quarterly and
5 may meet at other times at the discretion of the chairperson
6 and members. The committee shall comply with rules adopted by
7 the agency, including notice of any meeting of the committee
8 pursuant to the requirements of the Administrative Procedure
9 Act.

10 (4) Upon recommendation of the ~~Medicaid Pharmaceutical~~
11 ~~and Therapeutics~~ committee, the agency shall adopt a preferred
12 drug list as described in s. 409.912(39). To the extent
13 feasible, the committee shall review all drug classes included
14 on in the preferred drug list formulary at least every 12
15 months, and may recommend additions to and deletions from the
16 preferred drug list formulary, such that the preferred drug
17 list formulary provides for medically appropriate drug
18 therapies for Medicaid patients which achieve cost savings
19 contained in the General Appropriations Act.

20 ~~(5) Except for mental health-related drugs,~~
21 ~~antiretroviral drugs, and drugs for nursing home residents and~~
22 ~~other institutional residents, reimbursement of drugs not~~
23 ~~included in the formulary is subject to prior authorization.~~

24 (5)(6) The agency ~~for Health Care Administration~~ shall
25 publish and disseminate the preferred drug list formulary to
26 all Medicaid providers in the state by Internet posting on the
27 agency's website or in other media.

28 (6)(7) The committee shall ensure that interested
29 parties, including pharmaceutical manufacturers agreeing to
30 provide a supplemental rebate as outlined in this chapter,
31 have an opportunity to present public testimony to the

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1 committee with information or evidence supporting inclusion of
2 a product on the preferred drug list. Such public testimony
3 shall occur prior to any recommendations made by the committee
4 for inclusion or exclusion from the preferred drug list. Upon
5 timely notice, the agency shall ensure that any drug that has
6 been approved or had any of its particular uses approved by
7 the United States Food and Drug Administration under a
8 priority review classification will be reviewed by the
9 ~~Medicaid Pharmaceutical and Therapeutics~~ committee at the next
10 regularly scheduled meeting following 12 months of
11 distribution of the drug to the general public. ~~To the extent~~
12 ~~possible, upon notice by a manufacturer the agency shall also~~
13 ~~schedule a product review for any new product at the next~~
14 ~~regularly scheduled Medicaid Pharmaceutical and Therapeutics~~
15 ~~Committee.~~

16 ~~(8) Until the Medicaid Pharmaceutical and Therapeutics~~
17 ~~Committee is appointed and a preferred drug list adopted by~~
18 ~~the agency, the agency shall use the existing voluntary~~
19 ~~preferred drug list adopted pursuant to s. 72, chapter~~
20 ~~2000-367, Laws of Florida. Drugs not listed on the voluntary~~
21 ~~preferred drug list will require prior authorization by the~~
22 ~~agency or its contractor.~~

23 ~~(7)(9) The Medicaid Pharmaceutical and Therapeutics~~
24 ~~committee shall develop its preferred drug list~~
25 ~~recommendations by considering the clinical efficacy, safety,~~
26 ~~and cost-effectiveness of a product. When the preferred drug~~
27 ~~formulary is adopted by the agency, if a product on the~~
28 ~~formulary is one of the first four brand-name drugs used by a~~
29 ~~recipient in a month the drug shall not require prior~~
30 ~~authorization.~~

31 (8) Upon timely notice, the agency shall ensure that

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1 any therapeutic class of drugs which includes a drug that has
2 been removed from distribution to the public by its
3 manufacturer or the United States Food and Drug Administration
4 or has been required to carry a black box warning label by the
5 United States Food and Drug Administration because of safety
6 concerns is reviewed by the committee at the next regularly
7 scheduled meeting. After such review, the committee must
8 recommend whether to retain the therapeutic class of drugs or
9 subcategories of drugs within a therapeutic class on the
10 preferred drug list and whether to institute prior
11 authorization requirements necessary to ensure patient safety.

12 (9)~~(10)~~ The Medicaid Pharmaceutical and Therapeutics
13 Committee may also make recommendations to the agency
14 regarding the prior authorization of any prescribed drug
15 covered by Medicaid.

16 (10)~~(11)~~ Medicaid recipients may appeal agency
17 preferred drug formulary decisions using the Medicaid fair
18 hearing process administered by the Department of Children and
19 Family Services.

20 Section 11. Paragraph (a) of subsection (39) and
21 subsections (44) and (49) of section 409.912, Florida
22 Statutes, are amended, and subsection (50) is added to that
23 section, to read:

24 409.912 Cost-effective purchasing of health care.--The
25 agency shall purchase goods and services for Medicaid
26 recipients in the most cost-effective manner consistent with
27 the delivery of quality medical care. To ensure that medical
28 services are effectively utilized, the agency may, in any
29 case, require a confirmation or second physician's opinion of
30 the correct diagnosis for purposes of authorizing future
31 services under the Medicaid program. This section does not

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1 restrict access to emergency services or poststabilization
2 care services as defined in 42 C.F.R. part 438.114. Such
3 confirmation or second opinion shall be rendered in a manner
4 approved by the agency. The agency shall maximize the use of
5 prepaid per capita and prepaid aggregate fixed-sum basis
6 services when appropriate and other alternative service
7 delivery and reimbursement methodologies, including
8 competitive bidding pursuant to s. 287.057, designed to
9 facilitate the cost-effective purchase of a case-managed
10 continuum of care. The agency shall also require providers to
11 minimize the exposure of recipients to the need for acute
12 inpatient, custodial, and other institutional care and the
13 inappropriate or unnecessary use of high-cost services. The
14 agency may mandate prior authorization, drug therapy
15 management, or disease management participation for certain
16 populations of Medicaid beneficiaries, certain drug classes,
17 or particular drugs to prevent fraud, abuse, overuse, and
18 possible dangerous drug interactions. The Pharmaceutical and
19 Therapeutics Committee shall make recommendations to the
20 agency on drugs for which prior authorization is required. The
21 agency shall inform the Pharmaceutical and Therapeutics
22 Committee of its decisions regarding drugs subject to prior
23 authorization. The agency is authorized to limit the entities
24 it contracts with or enrolls as Medicaid providers by
25 developing a provider network through provider credentialing.
26 The agency may limit its network based on the assessment of
27 beneficiary access to care, provider availability, provider
28 quality standards, time and distance standards for access to
29 care, the cultural competence of the provider network,
30 demographic characteristics of Medicaid beneficiaries,
31 practice and provider-to-beneficiary standards, appointment

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1 wait times, beneficiary use of services, provider turnover,
2 provider profiling, provider licensure history, previous
3 program integrity investigations and findings, peer review,
4 provider Medicaid policy and billing compliance records,
5 clinical and medical record audits, and other factors.
6 Providers shall not be entitled to enrollment in the Medicaid
7 provider network. The agency is authorized to seek federal
8 waivers necessary to implement this policy.

9 (39)(a) The agency shall implement a Medicaid
10 prescribed-drug spending-control program that includes the
11 following components:

12 1. A Medicaid preferred drug list, which shall be a
13 listing of cost-effective therapeutic options recommended by
14 the Medicaid Pharmacy and Therapeutics Committee established
15 pursuant to s. 409.91195 and adopted by the agency for each
16 therapeutic class on the preferred drug list. At the
17 discretion of the committee, and when feasible, the preferred
18 drug list should include at least two products in a
19 therapeutic class. Medicaid prescribed-drug coverage for
20 ~~brand-name drugs for adult~~ Medicaid recipients is limited to
21 eight drugs per month ~~the dispensing of four brand-name drugs~~
22 ~~per month per recipient.~~ Prior authorization is required for
23 all additional prescriptions above the eight-drug limit and
24 must meet step therapy and preferred drug list listing
25 requirements. ~~Children are exempt from this restriction.~~
26 ~~Antiretroviral agents are excluded from this limitation. No~~
27 ~~requirements for prior authorization or other restrictions on~~
28 ~~medications used to treat mental illnesses such as~~
29 ~~schizophrenia, severe depression, or bipolar disorder may be~~
30 ~~imposed on Medicaid recipients. Medications that will be~~
31 ~~available without restriction for persons with mental~~

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1 ~~illnesses include atypical antipsychotic medications,~~
2 ~~conventional antipsychotic medications, selective serotonin~~
3 ~~reuptake inhibitors, and other medications used for the~~
4 ~~treatment of serious mental illnesses.~~ The agency shall also
5 limit the amount of a prescribed drug dispensed to no more
6 than a 34-day supply unless the drug products' smallest
7 marketed package is greater than a 34-day supply, or the drug
8 is determined by the agency to be a maintenance drug in which
9 case a 100-day maximum supply may be authorized. The agency is
10 authorized to seek any federal waivers necessary to implement
11 these cost-control programs and to continue participation in
12 the federal Medicaid rebate program, or alternatively to
13 negotiate state-only manufacturer rebates. The agency may
14 adopt rules to implement this subparagraph. ~~The agency shall~~
15 ~~continue to provide unlimited generic drugs, contraceptive~~
16 ~~drugs and items, and diabetic supplies. Although a drug may be~~
17 ~~included on the preferred drug formulary, it would not be~~
18 ~~exempt from the four-brand limit. The agency may authorize~~
19 ~~exceptions to the brand-name-drug restriction based upon the~~
20 ~~treatment needs of the patients, only when such exceptions are~~
21 ~~based on prior consultation provided by the agency or an~~
22 ~~agency contractor, but~~ The agency must establish procedures to
23 ensure that:

24 a. There will be a response to a request for prior
25 consultation by telephone or other telecommunication device
26 within 24 hours after receipt of a request for prior
27 consultation; and

28 b. A 72-hour supply of the drug prescribed will be
29 provided in an emergency or when the agency does not provide a
30 response within 24 hours as required by sub-subparagraph a.7
31 and

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1 ~~c. Except for the exception for nursing home residents~~
2 ~~and other institutionalized adults and except for drugs on the~~
3 ~~restricted formulary for which prior authorization may be~~
4 ~~sought by an institutional or community pharmacy, prior~~
5 ~~authorization for an exception to the brand-name drug~~
6 ~~restriction is sought by the prescriber and not by the~~
7 ~~pharmacy. When prior authorization is granted for a patient in~~
8 ~~an institutional setting beyond the brand-name drug~~
9 ~~restriction, such approval is authorized for 12 months and~~
10 ~~monthly prior authorization is not required for that patient.~~

11 2. Reimbursement to pharmacies for Medicaid prescribed
12 drugs shall be set at the lesser of: the average wholesale
13 price (AWP) minus 15.4 percent, the wholesaler acquisition
14 cost (WAC) plus 5.75 percent, the federal upper limit (FUL),
15 the state maximum allowable cost (SMAC), or the usual and
16 customary (UAC) charge billed by the provider.

17 3. The agency shall develop and implement a process
18 for managing the drug therapies of Medicaid recipients who are
19 using significant numbers of prescribed drugs each month. The
20 management process may include, but is not limited to,
21 comprehensive, physician-directed medical-record reviews,
22 claims analyses, and case evaluations to determine the medical
23 necessity and appropriateness of a patient's treatment plan
24 and drug therapies. The agency may contract with a private
25 organization to provide drug-program-management services. The
26 Medicaid drug benefit management program shall include
27 initiatives to manage drug therapies for HIV/AIDS patients,
28 patients using 20 or more unique prescriptions in a 180-day
29 period, and the top 1,000 patients in annual spending. The
30 agency shall enroll any Medicaid recipient in the drug benefit
31 management program if he or she meets the specifications of

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1 | this provision and is not enrolled in a Medicaid health
2 | maintenance organization.

3 | 4. The agency may limit the size of its pharmacy
4 | network based on need, competitive bidding, price
5 | negotiations, credentialing, or similar criteria. The agency
6 | shall give special consideration to rural areas in determining
7 | the size and location of pharmacies included in the Medicaid
8 | pharmacy network. A pharmacy credentialing process may include
9 | criteria such as a pharmacy's full-service status, location,
10 | size, patient educational programs, patient consultation,
11 | disease-management services, and other characteristics. The
12 | agency may impose a moratorium on Medicaid pharmacy enrollment
13 | when it is determined that it has a sufficient number of
14 | Medicaid-participating providers.

15 | 5. The agency shall develop and implement a program
16 | that requires Medicaid practitioners who prescribe drugs to
17 | use a counterfeit-proof prescription pad for Medicaid
18 | prescriptions. The agency shall require the use of
19 | standardized counterfeit-proof prescription pads by
20 | Medicaid-participating prescribers or prescribers who write
21 | prescriptions for Medicaid recipients. The agency may
22 | implement the program in targeted geographic areas or
23 | statewide.

24 | 6. The agency may enter into arrangements that require
25 | manufacturers of generic drugs prescribed to Medicaid
26 | recipients to provide rebates of at least 15.1 percent of the
27 | average manufacturer price for the manufacturer's generic
28 | products. These arrangements shall require that if a
29 | generic-drug manufacturer pays federal rebates for
30 | Medicaid-reimbursed drugs at a level below 15.1 percent, the
31 | manufacturer must provide a supplemental rebate to the state

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1 in an amount necessary to achieve a 15.1-percent rebate level.

2 7. The agency may establish a preferred drug list as
3 described in this subsection ~~formulary in accordance with 42~~
4 ~~U.S.C. s. 1396r-8~~, and, pursuant to the establishment of such
5 preferred drug list ~~formulary~~, it is authorized to negotiate
6 supplemental rebates from manufacturers that are in addition
7 to those required by Title XIX of the Social Security Act and
8 at no less than 14 percent of the average manufacturer price
9 as defined in 42 U.S.C. s. 1396r-8 on the last day of a quarter
10 unless the federal or supplemental rebate, or both, equals or
11 exceeds 29 percent. There is no upper limit on the
12 supplemental rebates the agency may negotiate. The agency may
13 determine that specific products, brand-name or generic, are
14 competitive at lower rebate percentages. Agreement to pay the
15 minimum supplemental rebate percentage will guarantee a
16 manufacturer that the Medicaid Pharmaceutical and Therapeutics
17 Committee will consider a product for inclusion on the
18 preferred drug list ~~formulary~~. However, a pharmaceutical
19 manufacturer is not guaranteed placement on the preferred drug
20 list ~~formulary~~ by simply paying the minimum supplemental
21 rebate. Agency decisions will be made on the clinical efficacy
22 of a drug and recommendations of the Medicaid Pharmaceutical
23 and Therapeutics Committee, as well as the price of competing
24 products minus federal and state rebates. The agency is
25 authorized to contract with an outside agency or contractor to
26 conduct negotiations for supplemental rebates. For the
27 purposes of this section, the term "supplemental rebates"
28 means cash rebates. Effective July 1, 2004, value-added
29 programs as a substitution for supplemental rebates are
30 prohibited. The agency is authorized to seek any federal
31 waivers to implement this initiative.

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1 ~~8. The agency shall establish an advisory committee~~
2 ~~for the purposes of studying the feasibility of using a~~
3 ~~restricted drug formulary for nursing home residents and other~~
4 ~~institutionalized adults. The committee shall be comprised of~~
5 ~~seven members appointed by the Secretary of Health Care~~
6 ~~Administration. The committee members shall include two~~
7 ~~physicians licensed under chapter 458 or chapter 459; three~~
8 ~~pharmacists licensed under chapter 465 and appointed from a~~
9 ~~list of recommendations provided by the Florida Long-Term Care~~
10 ~~Pharmacy Alliance; and two pharmacists licensed under chapter~~
11 ~~465.~~

12 ~~8.9.~~ The Agency for Health Care Administration shall
13 expand home delivery of pharmacy products. To assist Medicaid
14 patients in securing their prescriptions and reduce program
15 costs, the agency shall expand its current mail-order-pharmacy
16 diabetes-supply program to include all generic and brand-name
17 drugs used by Medicaid patients with diabetes. Medicaid
18 recipients in the current program may obtain nondiabetes drugs
19 on a voluntary basis. This initiative is limited to the
20 geographic area covered by the current contract. The agency
21 may seek and implement any federal waivers necessary to
22 implement this subparagraph.

23 ~~9.10.~~ The agency shall limit to one dose per month any
24 drug prescribed to treat erectile dysfunction.

25 ~~10.a.11.a.~~ The agency shall implement a Medicaid
26 behavioral drug management system. The agency may contract
27 with a vendor that has experience in operating behavioral drug
28 management systems to implement this program. The agency is
29 authorized to seek federal waivers to implement this program.

30 b. The agency, in conjunction with the Department of
31 Children and Family Services, may implement the Medicaid

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1 behavioral drug management system that is designed to improve
2 the quality of care and behavioral health prescribing
3 practices based on best practice guidelines, improve patient
4 adherence to medication plans, reduce clinical risk, and lower
5 prescribed drug costs and the rate of inappropriate spending
6 on Medicaid behavioral drugs. The program shall include the
7 following elements:

8 (I) Provide for the development and adoption of best
9 practice guidelines for behavioral health-related drugs such
10 as antipsychotics, antidepressants, and medications for
11 treating bipolar disorders and other behavioral conditions;
12 translate them into practice; review behavioral health
13 prescribers and compare their prescribing patterns to a number
14 of indicators that are based on national standards; and
15 determine deviations from best practice guidelines.

16 (II) Implement processes for providing feedback to and
17 educating prescribers using best practice educational
18 materials and peer-to-peer consultation.

19 (III) Assess Medicaid beneficiaries who are outliers
20 in their use of behavioral health drugs with regard to the
21 numbers and types of drugs taken, drug dosages, combination
22 drug therapies, and other indicators of improper use of
23 behavioral health drugs.

24 (IV) Alert prescribers to patients who fail to refill
25 prescriptions in a timely fashion, are prescribed multiple
26 same-class behavioral health drugs, and may have other
27 potential medication problems.

28 (V) Track spending trends for behavioral health drugs
29 and deviation from best practice guidelines.

30 (VI) Use educational and technological approaches to
31 promote best practices, educate consumers, and train

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1 prescribers in the use of practice guidelines.

2 (VII) Disseminate electronic and published materials.

3 (VIII) Hold statewide and regional conferences.

4 (IX) Implement a disease management program with a
5 model quality-based medication component for severely mentally
6 ill individuals and emotionally disturbed children who are
7 high users of care.

8 ~~c. If the agency is unable to negotiate a contract~~
9 ~~with one or more manufacturers to finance and guarantee~~
10 ~~savings associated with a behavioral drug management program~~
11 ~~by September 1, 2004, the four-brand drug limit and preferred~~
12 ~~drug list prior-authorization requirements shall apply to~~
13 ~~mental health-related drugs, notwithstanding any provision in~~
14 ~~subparagraph 1. The agency is authorized to seek federal~~
15 ~~waivers to implement this policy.~~

16 ~~11.12.~~ The agency is authorized to contract for drug
17 rebate administration, including, but not limited to,
18 calculating rebate amounts, invoicing manufacturers,
19 negotiating disputes with manufacturers, and maintaining a
20 database of rebate collections.

21 ~~12.13.~~ The agency may specify the preferred daily
22 dosing form or strength for the purpose of promoting best
23 practices with regard to the prescribing of certain drugs as
24 specified in the General Appropriations Act and ensuring
25 cost-effective prescribing practices.

26 ~~13.14.~~ The agency may require prior authorization for
27 the off-label use of Medicaid-covered prescribed drugs as
28 specified in the General Appropriations Act. The agency may,
29 but is not required to, preauthorize the use of a product for
30 an indication not in the approved labeling. Prior
31 authorization may require the prescribing professional to

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1 provide information about the rationale and supporting medical
2 evidence for the off-label use of a drug.

3 14. The agency, in conjunction with the Pharmaceutical
4 and Therapeutics Committee, may require age-related prior
5 authorizations for certain prescribed drugs. The agency may
6 preauthorize the use of a drug for a recipient who may not
7 meet the age requirement or may exceed the length of therapy
8 for use of this product as recommended by the manufacturer and
9 approved by the Food and Drug Administration. Prior
10 authorization may require the prescribing professional to
11 provide information about the rationale and supporting medical
12 evidence for the use of a drug.

13 15. The agency shall implement a step-therapy-prior
14 authorization-approval process for medications excluded from
15 the preferred drug list. Medications listed on the preferred
16 drug list must be used within the previous 12 months prior to
17 the alternative medications that are not listed. The
18 step-therapy-prior authorization may require the prescriber to
19 use the medications of a similar drug class or for a similar
20 medical indication unless contraindicated in the Food and Drug
21 Administration labeling. The trial period between the
22 specified steps may vary according to the medical indication.
23 The step-therapy-approval process shall be developed in
24 accordance with the committee as stated in s. 409.91195(7) and
25 (8).

26 16.15. The agency shall implement a return and reuse
27 program for drugs dispensed by pharmacies to institutional
28 recipients, which includes payment of a \$5 restocking fee for
29 the implementation and operation of the program. The return
30 and reuse program shall be implemented electronically and in a
31 manner that promotes efficiency. The program must permit a

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1 | pharmacy to exclude drugs from the program if it is not
2 | practical or cost-effective for the drug to be included and
3 | must provide for the return to inventory of drugs that cannot
4 | be credited or returned in a cost-effective manner.

5 | (44) The Agency for Health Care Administration shall
6 | ensure that any Medicaid managed care plan as defined in s.
7 | 409.9122(2)(h), whether paid on a capitated basis or a shared
8 | savings basis, is cost-effective. For purposes of this
9 | subsection, the term "cost-effective" means that a network's
10 | per-member, per-month costs to the state, including, but not
11 | limited to, fee-for-service costs, administrative costs, and
12 | case-management fees, if any, must be no greater than the
13 | state's costs associated with contracts for Medicaid services
14 | established under subsection (3), which shall be actuarially
15 | adjusted for case mix, model, and service area. The agency
16 | shall conduct actuarially sound audits adjusted for case mix
17 | and model in order to ensure such cost-effectiveness and shall
18 | publish the audit results on its Internet website and submit
19 | the audit results annually to the Governor, the President of
20 | the Senate, and the Speaker of the House of Representatives no
21 | later than December 31 of each year. Contracts established
22 | pursuant to this subsection which are not cost-effective may
23 | not be renewed.

24 | (49) The agency shall contract with established
25 | minority physician networks that provide services to
26 | historically underserved minority patients. The networks must
27 | provide cost-effective Medicaid services, comply with the
28 | requirements to be a MediPass provider, and provide their
29 | primary care physicians with access to data and other
30 | management tools necessary to assist them in ensuring the
31 | appropriate use of services, including inpatient hospital

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1 services and pharmaceuticals.

2 (a) The agency shall provide for the development and
3 expansion of minority physician networks in each service area
4 to provide services to Medicaid recipients who are eligible to
5 participate under federal law and rules.

6 (b) The agency shall reimburse each minority physician
7 network as a fee-for-service provider, including the case
8 management fee for primary care, if any, or as a capitated
9 rate provider for Medicaid services. Any savings shall be
10 shared with the minority physician networks pursuant to the
11 contract.

12 (c) For purposes of this subsection, the term
13 "cost-effective" means that a network's per-member, per-month
14 costs to the state, including, but not limited to,
15 fee-for-service costs, administrative costs, and
16 case-management fees, if any, must be no greater than the
17 state's costs associated with contracts for Medicaid services
18 established under subsection (3), which shall be actuarially
19 adjusted for case mix, model, and service area. The agency
20 shall conduct actuarially sound audits adjusted for case mix
21 and model in order to ensure such cost-effectiveness and shall
22 publish the audit results on its Internet website and submit
23 the audit results annually to the Governor, the President of
24 the Senate, and the Speaker of the House of Representatives no
25 later than December 31. Contracts established pursuant to this
26 subsection which are not cost-effective may not be renewed.

27 (d) The agency may apply for any federal waivers
28 needed to implement this subsection.

29 (50) The agency shall implement a program of
30 all-inclusive care for children. The program of all-inclusive
31 care for children shall be established to provide in-home

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1 hospice-like support services to children diagnosed with a
2 life-threatening illness and enrolled in the Children's
3 Medical Services network to reduce hospitalizations as
4 appropriate. The agency, in consultation with the Department
5 of Health, may implement the program of all-inclusive care for
6 children after obtaining approval from the Centers for
7 Medicare and Medicaid Services.

8 Section 12. Section 409.9124, Florida Statutes, is
9 amended to read:

10 409.9124 Managed care reimbursement.--

11 ~~(1)~~ The agency shall develop and adopt by rule a
12 methodology for reimbursing managed care plans.

13 ~~(1)(2)~~ Final managed care rates shall be published
14 annually prior to September 1 of each year, based on
15 methodology that:

16 (a) Uses Medicaid's fee-for-service expenditures.

17 (b) Is certified as an actuarially sound computation
18 of Medicaid fee-for-service expenditures for comparable groups
19 of Medicaid recipients and includes all fee-for-service
20 expenditures, including those fee-for-service expenditures
21 attributable to recipients who are enrolled for a portion of a
22 year in a managed care plan or waiver program.

23 ~~(c) Is compliant with applicable federal laws and~~
24 ~~regulations, including, but not limited to, the requirements~~
25 ~~to include an allowance for administrative expenses and to~~
26 ~~account for all fee-for-service expenditures, including~~
27 ~~fee-for-service expenditures for those groups enrolled for~~
28 ~~part of a year.~~

29 ~~(2)(3)~~ Each year prior to establishing new managed
30 care rates, the agency shall review all prior year adjustments
31 for changes in trend, and shall reduce or eliminate those

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1 adjustments which are not reasonable and which reflect
2 policies or programs which are not in effect.

3 ~~(3)(4)~~ The agency shall by rule prescribe those items
4 of financial information which each managed care plan shall
5 report to the agency, in the time periods prescribed by rule.
6 In prescribing items for reporting and definitions of terms,
7 the agency shall consult with the Office of Insurance
8 Regulation of the Financial Services Commission wherever
9 possible.

10 ~~(4)(5)~~ The agency shall quarterly examine the
11 financial condition of each managed care plan, and its
12 performance in serving Medicaid patients, and shall utilize
13 examinations performed by the Office of Insurance Regulation
14 wherever possible.

15 Section 13. Except as expressly otherwise provided in
16 this act, this act shall take effect July 1, 2005.

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